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CASE NO.: 1997-BLA-1653

IN THE MATTER OF

VARIS CANFIELD,
Claimant
v.

MAJESTIC MINING, INC.,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party in Interest

APPEARANCES:

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For the Claimant

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For the Employer

DECISION AND ORDER ON SECOND REMAND

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I. ISSUES ON SECOND REMAND

On June 20, 2001, the Benefits Review Board issued a Decision and Order remanding this case for a second time to (1) compare and weigh the *radiological* qualifications of the physicians interpreting Claimant's x-rays pursuant to Section 718.202 (a)(1) as well as the persuasiveness of their x-ray reports along with other relevant evidence on the existence of pneumoconiosis; (2) clarify my finding regarding Dr. Craft's opinion of Claimant's condition; (3) reconsider the medical opinion evidence of Drs. Bellotte, Crisalli, Fino, Hippensteel, Kress and Loudon; (4) determine whether Claimant has established the existence of pneumoconiosis or that pneumoconiosis was at least a contributing cause of a totally disabling respiratory impairment and therefore a material change in conditions; and (5) should I find for the Claimant, to determine the onset date of his disability.

In remanding this case the Board noted that *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000) established the standard for review. The Fourth Circuit held that in order for a claimant to obtain black lung benefits, said individual must prove by a preponderance of the evidence that (1) he has pneumoconiosis; (2) the pneumoconiosis arose out of his coal mine employment; (3) he has a totally disabling respiratory or pulmonary condition, and (4) pneumoconiosis is a contributing cause to his total respiratory disability. *Id*. at 207. The Fourth Circuit also held, contrary to the Board's view, that 20

C.F.R. § 718.202(a) required consideration of all relevance evidence rather than mere discrete subsections of § 718.202(a), *Id*. at 208, and specifically encouraged ALJ's to be mindful of the distinction between medical or clinical pneumoconiosis, characterized by certain opacities appearing on a chest x-ray and clinically described as chronic lung disease marked by an over growth of connective tissue caused by the inhalation of certain dusts, and legal pneumoconiosis, described as "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to or substantially aggravated by dust exposure in coal mine employment." *Id*. at 210 fn. 8 (quoting 20 C.F.R. § 718.201(a)(2) (2000)).

II. DISCUSSION

1. Existence of Pneumoconiosis

Before a claimant may obtain black lung benefits, the claimant must prove by a preponderance of the evidence that he has pneumoconiosis. *Compton*, 211 F.3d at 207. A finding of pneumoconiosis may be made by a chest X-ray, through the application of presumptions described in Sections 718.304-306, through an autopsy or biopsy, or, through a physician exercising sound medical judgment. 20 C.F.R. § 718.202(a)(1-4) (2000). The Fourth Circuit has mandated that all the evidence must be weighed together to determine the existence of pneumoconiosis and one of the tests outlined in Section 718.202(a)(1-4), is not necessarily dispositive of the issue. *Compton*, 211 F.3d at 209-11.

1(a) X-rays

X-ray evidence "may form the basis for a finding of the existence of pneumoconiosis." 20 C.F.R. § 718.202(a)(1) (2000). Numerical superiority is not a proper method for weighing conflicting x-ray evidence because such an approach encourages multiple readings in a quest for numbers, and illustrates little more than disparity in the financial resources of the parties. *Woodward v. Director, OWCP*, 991 F.2d 314, 321 (6th Cir. 1993). Under *Compton*, 211 F.3d at 210, the court noted that x-rays read as negative for coal workers' pneumoconiosis should not necessarily be treated as evidence weighing against a finding of legal pneumoconiosis. *See also*, *Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1195 (4th Cir. 1995)(distinguishing between medical and legal pneumoconiosis); *Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819, 821-22 (4th Cir. 1995)(same).

The record contains 16 different x-rays of Claimant's chest with 48 readings by the physicians listed below. Out of these 48 readings 6 were positive for the presence of pneumoconiosis (12/24/79; 3/14/81; 6/13/86; 10/14/88; 3/10/89; 2/16/96). The remaining were either negative or non-specific for the presence of pneumoconiosis as noted below.

Date of X-ray	Date of reading	Physician	Interpretation
03/27/72	6/22/73	Weinstein	0/0
03/02/73	08/10/73	J.R.	0/1
03/27/73		Goodwin	Nodular fibrosis of both lungs [film quality rated as "2"]
12/24/79	05/12/80	MSHA	Pneumoconiosis
03/14/81	03/14/81	Deardorff (BC)	1/2q; 2/1 t, cn
03/14/81	06/03/81	Sargent (BC/B)	Tobias
01/19/82	01/20/82	Tanguilig	Heart and lungs are within normal limits
03/28/85	03/28/85	Briley	No evidence of acute disease
03/28/85	05/29/85	Tanquilig	Mild degree of bilateral pulmonary emphysema
04/10/86	04/19/86	Gaziano (B)	Completely negative
04/10/86	05/19/86	Sargent (BC/B)	Completely negative [film quality is "foggy"]
04/10/86	09/15/88	Kress (B)	Completely negative [film quality is "underexposed"]
04/10/86	09/22/88	Gogineni (BC/B)	Completely negative [film quality is "light"]
04/10/86	09/26/88	Binns (BC/B)	0/1; s/t
06/13/86	09/03/86	Gaziano (B)	Completely negative [film quality rated as "2"]
06/13/86	07/29/86	Sargent (BC/B)	Negative for CWP [film quality is "fogged"]
06/13/86	06/17/86	Deardorff (BC/B)	1/0; s/s; cn
06/13/86	09/15/88	Kress (B)	Completely negative
06/13/86	09/22/88	Gogineni (BC/B)	Completely negative
06/13/86	09/26/88	Binns (BC/B)	0/1; s/t
10/14/88	10/14/88	Smith (BC)	1/0; p/s
10/14/88	12/04/88	Wiot (BC/B)	No CWP
10/14/88	12/06/88	Shipley (BC/B)	No CWP
10/14/88	12/07/88	Spitz (BC/B)	No CWP
10/14/88	12/13/88	Wershba (BC/B)	No CWP, mild COPD
10/14/88	1/13/89	Kress (B)	No CWP

10/14/88	12/13/89	Gogineni (BC/B)	No CWP; COPD
03/10/89	3/20/89	Speiden (BC/B)	1/1; t/u
03/10/89	07/03/89	Scott (BC/B)	Completely negative
03/10/89	07/03/89	Templeton (BC/B)	Completely negative
03/10/89	07/03/89	Wheeler (BC/B)	Completely negative
03/10/89	09/08/90	Duncan (BC/B)	0/1; s/s; em; no CWP
03/10/89	09/11/90	Hayes (BC/B)	No CWP; COPD
03/10/89	09/11/90	Wershba (BC/B)	Completely negative
01/11/90	03/07/91	Duncan (BC/B)	0/1; s/t; em [film quality is "light"]
01/11/90	03/11/91	Abramozitz (BC/B)	0/1; s/t, hyper expanded
01/11/90	03/12/90	Wershba (BC/B)	Completely negative [film quality is "light"]
11/07/92	11/08/92	ERT	Mild degree of bilateral non-specific Interstitial fibrosis. No active disease
09/06/95	09/07/95	DAS	Portable; pneumonia
02/16/96	03/06/96	Ranavaya (B)	Negative
02/16/96	02/16/96	Gaziano (B)	1/0; t/q
02/16/96	03/25/96	Franke (B/BCR)	0/1; q/t
02/16/96	02/24/97	Wiot (B/BCR)	No evidence of CWP; chest within normal limits. [film quality rated as "2"]
02/26/97	03/13/97	Leef	Insufficient evidence of OP; p/s; 0/1
02/26/97	07/03/97	Wiot (B/BCR)	No evidence of CWP [film quality rated as"2"]
02/26/97	07/08/97	Shipley (B/BCR)	No evidence of pneumoconiosis
02/26/97	07/10/97	Spitz (B/BCR)	No evidence of pneumoconiosis

1(a)(i) Film Quality

The x-ray must "be of suitable quality for proper classification of pneumoconiosis . . . ." 20 C.F.R. § 718.102(a) (2000). The administrative law judge, in his or her discretion, may accord less weight to x-ray interpretations where the reader has indicated that the x-ray film quality is less than optimal. *Arch on the North Fork, Inc. v. Bolling*, 145 F.3d 1329, 1998 WL 228131 (4th Cir. 1998)(Table)(stating that the ALJ did not err in considering that a negative reading was due to poor film quality when another superior quality film, albeit earlier, showed the existence of pneumoconiosis); *Fife v. Director, OWCP*, 888 F.2d 365, 369 (6th Cir. 1989)(stating that ALJ has discretion to discount a report based on unreliable

data). Of the negative readings, ten were made by readers who found the film to be of poor quality.

Dr. Kress complained that the x-ray taken on 4/10/86 was "underexposed," Dr. Sargent, complained that it was "foggy," and Dr. Gogineni reported that it was "light." On a scale of one-to-four, these readers determined the film quality was a "two." As these represent three of the five readings of the 04/10/86 x-ray, I find that all of the readings from the film taken on 04/10/86 are entitled to less weight.

Drs. Gaziano and Sargent also determined that x-ray taken on 06/13/86 had a substandard film quality. As such I give less weight to their negative readings. The remaining four readers of the 06/13/86 X-ray rated the film quality as a "one," and because the majority of the readers did not complain of poor film quality, I fully credit the remaining interpretations of the 06/13/86 x-ray.

Two of the three readers for the 01/11/90 x-ray indicated that the film quality was a "two," complaining that the film was "light." As these readings represent the majority of the readings from 01/11/90, I accord less weight to all the readings from that x-ray film.

Also, Dr. Wiot complained that the film quality was a "two," assigning an intelligible reason, for the x-rays taken on 02/16/96, and 02/26/97. Accordingly, I give less weight to Dr. Wiot's two readings because he had more difficulty reading the film than the six other interpreters of those two films. Therefore, twelve of the negative readings are entitled to less weight, because either the individual reader complained of poor film quality, or the majority of the readers of the particular x-ray determined that the film quality was poor.

1(a)(ii) Radiological Qualifications

Whenever two or more x-ray reports conflict, consideration shall be given to the radiological qualifications of the physicians interpreting the x-rays. 20 C.F.R. § 718.202(a)(1) (2000); *Adkins v. Director, OWCP*, 958 F.2d 49, 52 (4th Cir. 1992). The physician examining the x-ray film must submit a description and interpretation of his or her findings. 20 C.F.R. § 718.102(c) (2000). If the examiner "is a Board-certified or Board-eligible radiologist or a certified 'B' reader . . . he or she shall so indicate." *Id*. A physician who is Board-certified is one who has "certification in radiology or diagnostic roentgenology by the American Board of Radiology, Inc. or the American Osteopathic Association." 20 C.F.R. § 718.202(a)(1)(ii)(C) (2000). A certified B reader is one who "has demonstrated proficiency in evaluating chest roentgenograms for roentgenographic quality and in the use of ILO-U/C classification for interpreting chest roentgengrams for pneumoconiosis and other diseases by taking and passing a specially designed proficiency examination . . . ." 20 C.F.R. § 718.202(a)(1)(ii)(E) (2000). As the instant case stresses the ability to read an x-ray film, in the absence of other relevant factors, I accord more weight to those physicians who are both B readers and Board- certified. *See Freeman United Coal Co. v. Director, OWCP*, 988 F.2d 706, 708-9 (7th Cir. 1993)(allowing greater weight for interpretations by

Board-certified radiologists and B readers). The Board has cautioned against valuing the opinion of a B reader over that of a Board-certified radiologist. *See Roberts v. Bethlehem Mines Corp.*, 8 BLR. 1-211, 1-213 n.5 (1985)(taking "official notice that the qualifications of a certified radiologist are at least comparable if not superior to a physician certified as a reader pursuant to 42 C.F.R. § 37.51 . . . ."). Because I find that the interpretation of x-rays is a technical task, I give more weight to the practical experience of the physicians.

Out of the 6 positive readings, the 12/24/79 reading lists no physician, and is not entitled to any significant weight. Dr. Smith, a Board-certified radiologist, rendered a positive 1/0; p/s reading based on the 10/14/88 x-ray. Based off the x-ray taken on 3/14/81, Dr. Deardorff, Board-certified in 1981, gave a positive reading of 1/2q; 2/1 t, cn, and, also becoming a B reader, he gave a positive reading of 1/0; s/s; cn, based off the x-ray taken on 06/13/86. Dr. Speiden, Board-certified and a B reader, interpreted the 03/10/89 x-ray film as positive showing 1/1; t/u. The last positive reading was by Dr. Gaziano a B reader and Board-certified in pulmonary studies on 2/16/96.

On the other hand, Board-certified radiologist and B reader, Dr Sargent, rendered negative readings on the 04/10/86 and 06/13/86 films. Radiologist and B reader, Dr. Gogineni, rendered three negative readings from the films taken on 04/10/86, 06/13/86, and 10/14/88. Radiologist and B reader, Dr. Binns made 0/1 and s/t readings off the x-rays taken on 04/10/86 and 06/13/86. Radiologist and B reader, Dr. Wiot, made negative readings from the x-rays taken on 10/14/88, 02/16/96, and 02/26/97. Radiologist and B reader, Dr. Shipley rendered negative readings from the 10/14/88 and 02/26/97 films. Radiologist and B reader, Dr. Spitz also made negative readings on those two films. Radiologist and B reader Dr. Wershba rendered three negative readings from the X-rays taken on 10/14/88, 03/10/89, and 01/11/90. Radiologist and B readers, Drs. Scott, and Templeton each made a negative reading from the 03/10/89 X-ray. Radiologist and B reader, Dr. Duncan's negative readings from the 03/10/89 film were 0/1, s/s, em and 0/1, s/t, em as of 3/07/90. Radiologist and B readers, Drs. Hayes, and Abramozitz rendered negative findings based off the 03/10/89 and 01/11/90 films, respectively. Radiologist and B readers Dr. Franke found 0/1,q/t from the 02/16/96 X-ray, and Dr. Leef found insufficient evidence of OP, p/s, 0/1 based on the 02/26/97 film. B reader Drs. Kress, made negative readings based off the 04/10/86, 06/13/86, and 10/14/86 x-rays, and finally, Dr. Ranavaya, a B reader, made a negative reading based off the 02/16/96 film. Also, I note that Drs. Binns, Duncan, Abramozitz, Franke, and Leef all made diagnosis of 0/1, and while this is not "positive" for pneumoconiosis, it does show some dust retention in the lungs and does not strongly rebut a positive reading in the same manner as an interpretation that is completely negative.

Thus, the record in this case has numerous interpretations of numerous films by numerous physicians. The only readers to render a positive interpretation, who are both Board-certified radiologists and B readers, and whose interpretations is not credited with less weight because the film quality was not optimal, are Drs. Deardorff and Speiden. On the other hand, the only readers rendering negative interpretations, who are who are both Board-certified radiologists and B readers, and whose interpretations is not credited with less weight because the film quality was not optimal are Drs. Gogineni, Binns, Wiot,

Shipley, Spitz, Wershba, Scott, Templeton, Wheeler, Duncan, Hays and Franke.

Dr. Deardorff became a Board-certified radiologist in 1961, and by the time he rendered a positive reading in 1981, he had twenty years of experience, and by the time he rendered a positive reading in 1986, he had twenty-five years of experience in interpreting radiological data. Dr. Spieden, who rendered a positive reading on the 03/10/89 X-ray, became Board-certified in 1971, and became a B reader in 1985.

Comparatively, Dr. Wiot and Spitz are the only physician who have more experience, in terms of years of practice, as Board-certified radiologists by the time they read their last x-ray.[1] Dr. Wiot's qualifications, even apart from his long standing status as a board certified radiologist, are considerable. He helped write the standards for the ILO Classification scheme used to determine the existence of pneumoconiosis. He is also recognized as a C reader, a highly selective honor. Other courts have recognized his superior qualifications as well. *See e.g.*, *Dingess v. Peabody Coal Co.*, 194 F.3d 1304, 1999 WL 760252 (4th Cir. 1999)(Table)(finding it proper for the ALJ to accord the greatest weight to Dr. Wiot in light of the fact that he was a Board-certified radiologist, a B reader, and a prestigious professor who had authored numerous publications in the black lung field). Dr. Spitz also has an impressive curriculum vitae containing numerous publications and honors. Likewise, Dr. Deardorff is also a professor and has written numerous publications and earned many distinctions. Accordingly, based on the record, I find that, at the time of their last reading, Dr. Wiot is the most highly qualified physician, followed by Drs. Spitz and Deardorff.

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[1] The record reveals the length of experience for the following board certified radiologists and B readers:

Physician	Board Certification	B Reader	Years Experience at Last Interpretation
Wiot	1959	?	38
Deardorff	1961	1983	25
Spitz	1963	?	34
Wheeler	1969	?	20
Spieden	1971	1985	18
Binns	1974	1986	14
Wershba	1974	1984	16
Scott	1975	1984	14
Duncan	1977	1985	6
Gogineni	1980	1985	9
Shipley	1983	1985	14
Templeton	1987	1988	2
Hays	?	?	?
Franke	?	?	?

1(a)(iii) "Later is Better"

The Fourth Circuit rejected a "later is better" approach to evaluating x-ray evidence in *Adkins v. Director, OWCP*, 958 F.2d 49, 52 (4th Cir. 1992), reasoning that the ALJ cannot ignore the relative qualifications of competing physicians. The Supreme Court has, however, recognized that pneumoconiosis is a progressive disease. *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 151 (1987)(finding that the etiology of pneumoconiosis is "progressive and irreversible"). *See also, Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-59 (4th Cir. 2000)(finding that the ALJ did not err in applying the "later is better" rule when the later x-rays were consistent with the earlier x-rays); *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 530 (4th Cir. 1998)(recognizing pneumoconiosis as a progressive disease). Thus, because pneumoconiosis is a progressive disease, physicians who have the benefits of viewing several x-rays over a long period of time are in the best position to make a well reasoned interpretation of the x-ray evidence in determining whether a miner has pneumoconiosis.

Of the positive interpretations, only Drs. Deardorff and Gaziano had the opportunity to view more than one X-ray film. Dr. Deardorff viewed two x-rays spanning five years, and Dr. Gaziano viewed three x-rays covering a period of nearly ten years. Dr. Deardorff's interpretation is consistent in that he found pneumoconiosis apparent in both films. Similarly, Dr. Gaziano's interpretation's are consistent in that his two negative readings in 1986, were followed by a positive reading in 1996. I also note that Gaziano's two negative interpretations were on film of suspect quality.

Of the negative interpretations, only Drs. Sargent, Kress, Gogineni, Binns, Wiot, Shipley, Spitz, Duncan, and Wershba viewed more than one x-ray film. Dr. Sargent was prevented from rendering an interpretation on the 1981 film by the *Tobias* rule and that reading must be excluded from consideration. *See Tobias v. Republic Steel Corp.*, 2 BLR 1-1277 (1981). Thus, Dr. Sargent viewed two films, barely two months apart, in 1986, one of which was on film of poor quality, thus his interpretation is entitled to less weight. Dr. Kress, who is only a B reader, and Dr. Gogineni, each interpreted three different films, from 1986 to 1988, entitling their interpretation to less weight than Deardorff and Gaziano because their sampling of x-rays related to a shorter period of time. Likewise, Dr. Binns two readings in 1986 are entitled to less weight. Dr. Wiot made negative readings on three films covering the time period from 1988 to 1997. All of Dr. Wiot's interpretations were negative, however, Dr. Wiot indicated that the film quality in the later x-rays, from 1996 and 1997, were of poor quality, and his opinion on those films is entitled to less weight. Drs. Shipley and Spitz viewed two films, dated 1988 and 1997, rendering negative interpretations on both, entitling their interpretations to greater weight because they had the opportunity to view the progression, if any, of Claimant's pneumoconiosis. Dr. Duncan also viewed two films, but his sample spanned less than one year and his second reading was influenced by a "light" film. Dr. Wershba made readings from three films dated between 1988 to 1990. This short period, coupled with the fact that his last interpretation was influenced by the fact that the film quality was poor entitles his interpretation to less weight.

Accordingly, only the interpretations of Dr. Deardorff, Gaziano, Shipley and Spitz are entitled to their full probative value, *vis a vis* the other x-ray readers, because they had the benefit of viewing the most number of films over the longest period. I also note that Dr. Gaziano's interpretation of the x-ray evidence is consistent with the progressive nature of pneumoconiosis, he viewed three films over nine years, and his early negative interpretations were influenced by the fact that he, or the majority of other readers, rated the film quality as poor, and his final interpretation, on a clear x-ray, was positive. This fact distinguished Dr. Gaziano's interpretation from other multiple readers, like Dr. Wiot, because Dr. Gaziano's last film was clear, whereas Dr. Wiot's last two films were of suspect quality, meaning that Dr Wiot may not have clearly distinguished any progression of Claimant's pneumoconiosis. Additionally, I note that Dr. Deardorff gave consistently positive readings and Drs. Shipley and Spitz's readings were consistently negative.

1(a)(iv) Bias of X-ray Interpreters

In weighing the quality of numerous and diverse opinions, in addition to other factors, an "ALJ should consider whether an opinion was, to any degree, the product of bias in favor of the party retaining the expert and paying the fee. *Underwood v. Elkay Mining, Inc.*, 105 F.3d 946, 951 (4th Cir. 1997). *See also, Woodward v. Director, OWCP*, 991 F.2d 314, 321 (6th Cir. 1993)(holding that party affiliation of the experts is a proper consideration). Should the ALJ determine that an expert's opinion is not independently based on the facts, the ALJ has discretion to regard the experts opinion as having low probative value. *Underwood*, 105 F.3d at 951. Also, under the Federal Rules of Evidence, a judge may take judicial notice of facts that are "not subject to reasonable dispute" because they are "generally known within the territorial jurisdiction of the court," or because they are "capable of accurate and ready determination by sources whose accuracy cannot reasonably be questioned." FED. R. EVID. 201 (2001). The Benefits Review Board has cautioned, however, that the ALJ should base his credibility determinations based on the record as a whole and not rely upon outside information in finding a party is biased. *Melnick v. Consolidation Coal Co.*, 16 BLR 1-31, 1-35 (1991)(overturning an ALJ's decision to accord little probative weight to the opinions of Dr. Wiot and Spitz because, in the ALJ's long history of dealing with these two doctors, he ascertained that they would "pigeonhole [the] claimant's condition according to the desires of the paying party").

Operator's physicians, Drs. Wiot and Spitz have both worked at the Radiology Department at the University of Cincinnati. In the instant case, Dr. Wiot unequivocally found no evidence of pneumoconiosis on the x-rays taken on 10/14/88, 2/16/96 and 2/26/97. Dr. Spitz unequivocally found no evidence of pneumoconiosis based off the x-rays taken on 10/14/88 and 2/26/97. Other examining physicians of the same x-ray had either rated the film positive of pneumoconiosis or found insufficient evidence. By itself, this fact is not particular troubling, especially in a close cases where two equally qualified physicians could view the same x-ray and reach completely opposite results. After a review of Fourth and Sixth Circuit decisions, however, Drs. Wiot and Spitz's negative readings appear more than mere objective interpretations of the physical data, rather, the Circuit Court cases reveal that, statistically speaking, Drs.

Wiot and Spitz are anything but objective.[2] I take judicial notice of their apparent bias and accord their

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[2] Here I take notice of the fact that Dr. Wiot, in a survey of cases decided by the Circuit Court of Appeals, has consistently found that a miner's x-rays show no evidence of pneumoconiosis, when other physicians had reached the opposite conclusion. *See e.g, Dingess v. Peabody Coal Co.*, 194 F.3d 1304, 1999 WL 760252 (4th Cir. 1999)(Table)(finding that Dr. Wiot was one of eighteen readers interpreting an x-ray as negative when three other readers interpreted it as positive); *Arch of KY., Inc v. Hickman*, 188 F.3d 506, 1999 WL 646283 (6th Cir. 1999)(Table)(issuing a medical report negating the existence of pneumoconiosis in a case containing thirty-nine interpretations of x-ray evidence, nine of which were positive); *Toliver v. P.G.&H., Inc.*, 172 F.3d 864, 1999 WL 30896 (4th Cir. 1999)(Table)(finding that Claimant's counsel properly objected to the admissibility of x-ray rereading by Dr. Wiot); *Copley v. Arch of WVA, Inc.*, 135 F.3d 769 1998 WL 62602 (4th Cir. 1998)(Table)(crediting the interpretation of Dr. Wiot in determining that the x-ray evidence did not prove the existence of pneumoconiosis); *Staton v. Norfolk & Western Ry. Co.*, 65 F.3d 55 (6th Cir. 1995)(finding that of eight readers, only Drs. Wiot and Spitz determined that the film was completely negative); *Adkins v. Arch of WVA, Inc.*, 61 F.3d 899, 1995 WL 432403 (4th Cir. 1995)(Table)(finding that Dr. Wiot rendered a negative interpretation of an x-ray when two other physicians interpreted it as positive); *Wiley v. Consolidation Coal Co.*, 39 F.3d 1183, 1994 WL 592836 (6th Cir. 1994)(Table)(stating that Dr. Wiot gave one of two negative interpretations when three other physicians interpreted the x-ray as positive); *Journell v. Southern Appalachian Coal Co.*, 23 F.3d 401, 1994 WL 191634 (4th Cir. 1994)(Table)(stating that Dr. Wiot gave one of three negative readings when two other physicians gave positive readings); *Fox v. Director, OWCP*, 991 F.2d 789, 1993 WL 104306 (4th Cir. 1993)(Table)(relying on a negative interpretation of an x-ray read solely by Drs. Wiot, Spitz and Shipley to determine that the x-ray evidence did not show pneumoconiosis when earlier x-rays were interpreted as positive); *Walker v. GAF Corp.*, 885 F.2d 872, 1989 WL 109754 (6th Cir. 1989)(Table)(interpreting an x-ray as not showing asbestosis when there was medical evidence to the contrary); *Everly v. Peabody Coal Co.*, 848 F.2d 190, 1988 WL 40480 (6th Cir. 1988)(Table)(finding Dr. Wiot gave one of two negative interpretations when a third reader interpreted the film as positive) ; *Creech v. Benefits Review Bd.*, 841 F.2d 706 (6th Cir. 1988)(finding film quality unreadable when another physician rendered a positive interpretation); *Prater v. Hite Preparation Co.*, 829 F.2d 1363 (6th Cir. 1987)(relating that Drs. Wiot and Spitz rendered negative interpretations when other physicians found evidence of pneumoconiosis); *Frost v. Benefits Review Bd.*, 821 F.2d 649, 1987 WL 37851 (6th Cir. 1987)(Table)(finding no evidence of disk atelectasis when an earlier physician had determined that there were "U" shaped irregularities in the lower lung zones); *C.f. Sexton v. Switch Energy Coal Corp.*, - - F.3d - -, 2001 WL 1136086 (6th Cir. 2001)(Table)(attributing large opacities in lung to pneumoconiosis and also noting old tuberculosis); *England v. Director, OWCP*, 120 F.3d 260, 1997 WL 419328 (4th Cir. 1997)(Table)(conceding that a 1989 x-ray showed complicated pneumoconiosis when arguing that the onset date of total disability should be 1989, not 1986, the date the claim was filed).

Similarly, Dr. Spitz has consistently determined that an x-ray did not show evidence of pneumoconiosis in contested cases. *See e.g., Dingess v. Peabody Coal Co.*, 194 F.3d 1304, 1999 WL

interpretations less probative value.

1(a)(v) Comparing and Weighing the X-ray Evidence

760252 (4th Cir. 1999)(Table)(finding that Dr. Spitz was one of eighteen readers interpreting an x-ray as negative when three other readers interpreted it as positive); *Toliver v. P.G.&H., Inc.*, 172 F.3d 864, 1999 WL 30896 (4th Cir. 1999)(Table)(finding that Claimant's counsel properly objected to the admissibility of x-ray rereading by Dr. Spitz); *Copley v. Arch of WVA, Inc.*, 135 F.3d 769 1998 WL 62602 (4th Cir. 1998)(Table)(crediting the interpretation of Dr. Spitz in determining that the x-ray evidence did not prove the existence of pneumoconiosis); *Staton v. Norfolk & Western Ry. Co.*, 65 F.3d 55 (6th Cir. 1995)(finding that of eight readers, only Drs. Wiot and Spitz determined that the film was completely negative); *Adkins v. Arch of WVA, Inc.*, 61 F.3d 899 (4th Cir. 1995)(Table)(finding the Dr. Spitz rendered a negative interpretation of an x-ray when two other physicians interpreted it as positive); *Journell v. Southern Appalachian Coal Co.*, 23 F.3d 401, 1994 WL 191634 (4th Cir. 1994)(Table)(stating that Dr. Spitz gave one of three negative readings when two other physicians gave positive readings); *Woodward v. Director, OWCP*, 991 F.2d 314 (6th *Fox v. Director, OWCP*, 991 F.2d 789, 1993 WL 104306 (4th Cir. 1993)(Table)(relying on a negative interpretation of an x-ray read solely by Drs. Wiot and Spitz and Shipley to determine that the x-ray evidence did not show pneumoconiosis when earlier x-rays were interpreted as positive); *Craft v. Director, OWCP*, 867 F.2d 611, 1989 WL 8112 (6th Cir. 1989)(Table)(interpreting x-ray evidence as negative); *Mooney v. Secretary of Health and Human Services*, 836 F.2d 550, 1987 WL 30583 (6th Cir. 1987)(Table)(rendering consistently negative interpretation of films that other physicians determined were positive); *Prater v. Hite Preparation Co.*, 820 F.2d 1363 (6th Cir. 1987)(relating that Drs. Wiot and Spitz rendered negative interpretations when other physicians found evidence of pneumoconiosis); *Combs v. Secretary of Health and Human Services*, 820 F.2d 405, 1987 WL 36135 (6th Cir. 1987)(Table)(making negative interpretations of the x-rays when other physicians had interpretations as high as 2/2); *Couch v. Secretary of Health and Human Services*, 774 F.2d 163 (6th Cir. 1985)(reviewing an x-ray film earlier interpreted for pneumoconiosis at 2/2 and determining that the film was negative); *Peabody Coal Co. v. Lois*, 708 F.2d 266 (7th Cir. 1983)(rendering a negative reading). *C.f England v. Director, OWCP*, 120 F.3d 260, 1997 WL 419328 (4th Cir. 1997)(Table)(conceding that a 1989 x-ray showed complicated pneumoconiosis when arguing that the onset date of total disability should be 1989, not 1986, the date the claim was filed).

While I cannot say that Drs. Wiot and Spitz were biased in any one particular case, a review of the cases reveals an impermissible pattern of shaded interpretations. A review of cases which involved other x-ray interpreters does not reveal enough cases, nor such a one-sided pattern of negative, or positive, readings.

In weighing the evidence concerning the interpretations of the x-rays, I find that Claimant has established the existence of pneumoconiosis. First, the probative value of the x-rays taken on 04/10/86 and 01/11/90 are discounted because a majority of the readers looking at the film remarked that the quality was less than optimal. Also, the interpretations of Goodwin from the 1973 x-ray, Gaziano and Sargent from the 6/13/86 x-ray, and Wiot from the x-rays taken on 02/16/96 and 02/26/97, are also discounted because the readers related that they thought the film quality was less than optimal.

Second, based upon the radiological qualifications of the x-ray interpreters, I accord less weight to all those physicians who are neither Board-certified radiologists nor B readers, and accord greater weight to those who are both B readers and board certified. Dr. Wiot is the most qualified physician of record, as chairman of the University of Cincinnati Department of Radiology, and the lone physician to have the distinction of being a C reader. I also find that Drs. Spitz and Deardorff are highly qualified and entitle their opinion to greater weight.

Third, I accord greater weight to the interpretations of physicians who had the benefit of viewing x-rays over a long period of time. In this regard I give more credit to the interpretations of Dr. Deardorff, Gaziano, Shipley and Spitz because they had the benefit of viewing the most number of films over the longest period. I also note that all their interpretations of the x-ray evidence is consistent with the progressive nature of pneumoconiosis.

Fourth, I note that Drs. Wiot and Spitz have a publically recorded history of making one-sided interpretations and I view their findings as suspect. Additionally, I note that, while not all of the sixteen x-ray films are "positive," fifteen of those films either show some degree of dust in the lungs or other pulmonary impairment. Accordingly, based on all the x-ray evidence, I find that Claimant's X-rays establish the existence of pneumoconiosis.

1(b) Establishing Pneumoconiosis Through a Presumption

Aside from x-ray evidence, a coal miner may establish the existence of pneumoconiosis through an autopsy or biopsy, through a physician exercising sound medical judgment, or through the application of presumptions described in Sections 718.304-306. 20 C.F.R. § 718.202(a)(1-4) (2000). Here neither an autopsy nor a biopsy is available. Even if the x-ray evidence had turned out to be negative, however, Claimant is still entitled to the presumption of pneumoconiosis in Section 718.305, which provides:

> If a miner was employed for fifteen years or more in one or more underground coal mines, and if there is a chest X-ray submitted in connection with such miner's . . . claim, and it is interpreted as negative . . . and if other evidence demonstrates the existence of a totally disabling respiratory or pulmonary impairment, then there shall be a rebuttable presumption that such miner is totally disabled due to pneumoconiosis . . . . The presumption may be

> rebutted only by establishing that the miner does not, or did not have pneumoconiosis, or that his or her respiratory or pulmonary impairment did not arise out of, or in connection with, employment in a coal mine.

20 C.F.R. § 718.305(a) (2000).

At hearing both parties agreed that Claimant worked at least fifteen years in the coal mines, and has undisputed evidence of a totally disabling respiratory impairment. Thus, Claimant is entitled to the presumption of having pneumoconiosis.

1(c) Establishing Pneumoconiosis Through the Sound Medical Judgment of a Physician

A coal miner may establish the existence of pneumoconiosis through a physician exercising sound medical judgment. 20 C.F.R. § 718.202(a)(4) (2000). "An ALJ may not discredit a physician's opinion solely because the physician did not examine the claimant." *Clinchfield Coal Co. v. Smith*, - - F.3d - -, 2001 WL 848195 (4th Cir. 2001)(quoting *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 212 (4th Cir. 2000)). Statements made by the claimant, concerning the existence of pneumoconiosis, do not conclusively resolve conflicting medical opinions. *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 533 (4th Cir. 1998). A well reasoned medical opinion is one with underlying documentation adequate to support the physicians conclusions. *Jordan v. Benefits Review Board*, 876 F.2d 1455, 1460 (11th Cir. 1989). In determining if an opinion is well reasoned, an ALJ should examine the validity of the physician's reasoning "based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories." 20 C.F.R. § 718.202(a)(4) (2000). In the instant case Drs. Craft, Boggs, Stewart and Gaziano opined that Claimant has pneumoconiosis, and Drs. Crisalli, Fino, Bellotte, Hippensteel and Loudon concluded that Claimant does not have pneumoconiosis.

1(c)(i) The Medical Evidence

The following medical summary is reproduced from the Proposed Decision and Order; Memorandum of Conference, created by the District Director in 1997:

PULMONARY FUNCTION STUDIES

Date of Test	Physician	Height	Age	FEV_1	MVV	FCV	FEV_1/FVC
02/27/97	Crisalli	68"	71	0.057		1.58	36%

	Total Disability Standards. . .			1.74		2.25	55%
02/16/96	Gaziano	67"	70	0.70	28	1.78	40%
	Total disability Standards . . .			1.68	67	2.18	55%

These test results were reviewed by Dr. Ranavaya, pulmonary consultant to DOL, who found them to be VALID.

03/10/89	Rasmussen	67	64	1.18	48	2.41	48%
	Total Disability Standards . . .			1.78	71	2.28	55%
10/14/88	Crisalli	67	63	1.89	54	3.35	56.4%
	Total Disability Standards . . .			1.79	72	2.30	55%
08/23/86	Fritzhand	69	55	1.8	46	- -	- -
	Total Disability Standards . . .			2.08	83	2.63	55%
04/10/86	Gaziano	67	60	1.05	49	1.73	60.6%
	Total Disability Standards . . .			1.84	74	2.35	55%

These test results were reviewed by Dr. Gaziano, pulmonary consultant to DOL, who found them to be VALID.

08/83/83	Bellotte	69	58	1.89	60	2.53	74.7%
	Total Disability Standards . . .			2.03	81	2.58	55%

ARTERIAL BLOOD GAS STUDIES

Date of Test	Physician	PCO_2	PO_2	Type of Test
02/26/97	Crisalli	40	70	Resting
	PO_2 Disability Standard . . .		60	
02/16/96	Gaziano	47	59	Resting
	PO_2 Disability Standard . . .		60	

These results were viewed by Dr. Gaziano, pulmonary consultant to DOL, who found them to be VALID.

03/10/89	Rasmussen	40	56	Resting
		43	55	Exercise
	PO_2 Disability Standard . . .		60	
04/10/88	Crisalli	43.1	63.7	Resting
	PO_2 Disability Standard . . .		60	
04/10/86	Gaziano	34	63	Resting
	PO_2 Disability Standard . . .		66	
		32	66	Exercise
	PO_2 Disability Standard . . .		68	

These results were reviewed by Dr. Gaziano, pulmonary consultant to DOL, who found them to be VALID.

Accordingly, the results of the pulmonary function study clearly show that, as a percentage, Claimant's pulmonary functions continually decreased, with FEV_1 values rapidly declining after 1988. The blood-gas studies show that Claimant was within the disabled range from 1989 to 1996, but, the record shows an improvement in on PO_2 levels in 1997.

1(c)(ii) Medical & Work Histories

A physician's determination of the existence of pneumoconiosis, if it is a well reasoned medical opinion, should be based partly upon the Claimant's medical and work histories. 20 C.F.R. § 718.202(a)(4) (2000).

Claimant began working underground in the coal mines in 1943 at Elk River Coal and Lumber Company in Widen, West Virginia. (Tr. 12). Claimant returned to this job after serving a few years in the Navy during World War II. (Tr. 13). He then worked in a coal mine operated by a branch of Allied Chemical, and most recently worked for Operator, Majestic Mines, quitting on January 25, 1985. (Tr. 15). In 1991, Judge Burke, finding Claimant's testimony vague and inconsistent, determined that Claimant had eighteen years of coal mine experience, even though Claimant alleged twenty-six years in his application for benefits. On certain medical reports, Claimant has over thirty-five years of exposure working in the coal mines. Accordingly, Claimant has a long history of coal mine employment.

Regarding his smoking history, Claimant testified that he was not able to smoke in the mines. (Tr. 17-18). Claimant further testified that he may have smoked up to a pack of cigarettes a day, largely reducing his tobacco intake after 1985, and quitting in 1992. (Tr. 18). Later, however, Claimant testified that in a typical week before quitting the mines in 1985, he may not buy any cigarettes for a period of two or three weeks. (Tr. 22). Ingfrid Canfield, Claimant's spouse, testified that Claimant has had memory problems for the past five to ten years. (Tr. 40-41). Likewise, the smoking history Claimant gave to the

examining physicians ranges from never having smoked to one pack a day for forty years. In 1991, Judge Burke, again finding Claimant's testimony vague and unreliable, credited Claimant with smoking one-half pack of cigarettes a day for forty years. I find that Judge Burke's interpretation is reasonable and hold that Claimant smoked one-half pack of cigarettes a day for forty years.

1(c)(iii) The Medical Reports

While the opinions of treating physicians deserve special consideration, an ALJ must not mechanically credit, to the exclusion of all other testimony, the testimony of the treating physicians. *Sterling Smokeless coal Co. v. Akers*, 131 F.3d 438, 441 (4th Cir. 1997). *See also*, *Grigg v. Director, OWCP*, 28 F.3d 416, 420 (4th Cir. 1994)(stating that the testimony of a treating physician is entitled to great, though not necessarily dispositive, weight); *Burek v. Valley Camp Coal Co*, 2001 WL 687589, *7 (4th Cir. 2001)(Table)(stating that the opinion of a treating physician is entitled to great weight as it "reflects an expert judgment based on continued observation of the patient's condition over a prolonged period of time."). *Cf. Grizzle v. Picklands Mather and Co.*, 944 F.2d 1093, 1097-99 (4th Cir. 1993)(finding that a treating physicians evidence is not entitled to great weight as a matter of law and an ALJ is not required to weigh the opinion more heavily). A doctor gives a reasoned medical opinion when the totality of his report indicates that the doctor considered the objective medical evidence and the report may be well reasoned even if the doctor did not offer any explanation for his conclusions. *Compton*, 211 F.3d at 212.

1(c)(iii)(A) Physicians Not Finding Pneumoconiosis

Dr. Crisalli, a pulmonary disease specialist, opined that Claimants physical condition was solely related to tobacco smoking and his condition would be the same today had he never mined coal. (Crisalli Dep. 23 & 29). Dr. Crisalli credited Claimant with his heaviest account of his smoking history of one pack of cigarettes a day, opining that this was a significant smoking history. *Id* at 55. Additionally, in factoring in the interpretations of Claimant's x-ray films, Dr. Crisalli testified that:

> A All of these interpretations either show low grade changes which might be consistent with pneumoconiosis or else show that there are no shadows consistent with occupational pneumoconiosis. And in looking at the mix, I try to weigh the qualifications of the various radiologists. I weigh the numbers, how many said this or that, but that's a relatively minor factor, and just try to put it together as a whole.
>
> Q Doctor, is whether the x-ray interpretations ultimately come up positive or negative all you need to know in deciding whether or not a patient has coal workers; pneumoconiosis?
>
> A Certainly not. In evaluating a patient for coal workers' pneumoconiosis, I

approach them as I would any patient. I use the information obtained from the history, the physical exam, the pulmonary functions, and the x-ray to help arrive at an accurate diagnosis. . . .

(Crisalli Dep. 17-18)

Interpreting the x-ray evidence, Dr. Crisalli determined that they did not show evidence of pneumoconiosis. *Id*. at 23. In distinguishing between his diagnosis of emphysema related to tobacco use, and pulmonary impairments related to coal dust exposure, Dr. Crisalli stated:

A Sometimes it's a difficult situation to distinguish. In a situation where an individual has obstruction to air flow, no evidence of emphysema, and an x-ray which is 1/1, it may cause a problem, assuming that individual also has other exposures like smoking.

In a situation like this where there's clear-cut evidence of emphysema and there's an x-ray which overall shows no evidence of occupational pneumoconiosis and the patient has a heavy smoking history, the only reasonable medical conclusion is that the patient has emphysema secondary to tobacco smoke exposure.

(Crisalli Dep. 25).

Later Dr. Crisalli revealed the parameters for diagnosing coal miner's pneumoconiosis:

A . . . . It would be helpful if there were x-rays changes, but it's not absolutely necessary. Obstruction to air flow can occur in coal workers pneumoconiosis.

A restrictive change may occur in the pulmonary functions as well at certain changes of pneumoconiosis. I would like there to be coal dust exposure of a significant degree.

Whether there is hypoxemia or not, that is nonspecific and would not diagnosis pneumoconiosis. But if it were there, it would help me determine pulmonary impairment. . . .

Q . . . [D]id Mr. Canfield demonstrate any of those conditions?

A Yes. He has an obstruction to air flow on his pulmonary functions, . . .

Q . . . . How do you conclude a diagnosis of pneumoconiosis?

A . . . . Based on the history, there has to be a significant exposure. Physical exam findings are nonspecific. . . . If an individual came in here and had x-ray evidence

> of coal workers' pneumoconiosis and I found nothing else to suggest a cause of those x-ray changes and he had a significant coal dust exposure, then I would say you have coal workers' pneumoconiosis. . . .

(Crisalli Dep. 35-37).

Accordingly, Dr. Crisalli's medical opinion depends, in a large part, upon x-ray films that he interpreted to be negative, and upon an incorrect smoking history of a pack a day for forty years. Dr. Crisalli did credit Claimant with obstructive air flow on his pulmonary functions, and credited Claimant with a significant history of exposure to coal dust. Therefore, I find that Dr. Crisalli's diagnoses of the absence of pneumoconiosis is not a sound medical judgment, because, by his own reasoning, based upon the legally established facts, Dr. Crisalli would likely diagnose Claimant as having pneumoconiosis.

Operator also took the deposition testimony of Dr. Fino, board certified in internal medicine and a pulmonary disease specialist, to demonstrate that Claimant does not have pneumoconiosis. Dr. Fino did not personally examine Claimant, but, he did review a series of consultative reports, discharge summaries and the reports of Dr. Crisalli. (Fino Dep. 6). In part, Dr. Fino based his diagnosis that Claimant does not have pneumoconiosis, on the fact that Claimant showed improvement in his lungs after the use of bronchodilators. *Id*. at 17. In expressing his opinion, Dr. Fino stated:

> A I believe that you can distinguish between [pneumoconiosis and COPD], and it is not just because the chest x-ray in this particular case did not show pneumoconiosis, because we know that you can have pneumoconiosis in the absence of a positive chest x-ray, and we also know that there are cases of obstructive lung disease that can be seen in coal miners due to coal mine dust inhalation, but when I look at this particular case, there is a number of issues that really point to a non-coal mine dust related condition, granted, again, realizing that the chest x-ray is negative, but above and beyond that, number one, the obstruction that is present has been shown to be reversible with bronchodilators, and as I have already discussed, bronchodilators are not going to be effective in a coal mine dust related condition.
>
> There is great variability in the blood gases at rest, and as just discussed, variability in the blood gases with treatment, and variability is not consistent with a coal mine dust related condition, and if blood gases improve with treatment, that is not consistent with coal mine dust.
>
> There are elevated lung volumes, and elevated lung volumes are not what one would expect in a coal mine dust related condition.
>
> One would generally see the other abnormality in lung volumes, that is, reduced lung volumes.
>
> There has been a rather dramatic drop in this man's lung function over time.

> Back in 1988, which I think is just shortly after he stopped working, but he still was smoking, because the evidence clearly shows that he was still smoking, his FEV1 was 1.89 liters, and eight years later, it was down to .70 liters, so he has lost one thousand cc's or one liter of FEV1 in eight years, which is 125 cc per year drop in FEV1.
>
> That's well described in individuals who smoke, whether they continue to smoke or not, in terms of that degree of reduction or rapidity or intensity in lung function, but that is far and above much greater that has ever been described in a coal mine dust related condition, as those descriptions of reduction in FEV1 have actually been less that what has been seen in terms of aging, since when we age, our FEV1 decreases.
>
> On top of all that, when I look at the pattern of abnormality in these lung function studies, there is much more obstruction in the small airways, as measured by the FEF 25/75, than in the large airways, as measured by the FEV1, and that is not something that would be expected in a coal mine dust induced obstructive lung condition, but is quite consistent with what we see in a smoking related condition, so I do not believe that Mr. Canfield's progressive course, in terms of his lung function, his responses to bronchodilators, his clinical situation is any different than what I see in my own practice in cigarette smokers who never had industrial exposure, nor is this the typical pattern of abnormality that I have seen in my coal miners who suffer from coal mine induced lung impairment, so I believe that Mr. Canfield's abnormality in lung function in blood gases, in lung volumes, and diffusion are all related to his cigarette smoking.

(Fino Dep 17-20).

Thus, Dr. Fino bases his diagnosis on: 1) negative x-rays; 2) reversibility of condition with bronchodilators; 3) variability and improvement of the blood gases at rest and with treatment; 4) improvement in lung volumes; 5) a smoking history that would account for the drop in lung function; and 6) obstructions in the small airways.

Dr. Fino's analysis of the facts, however suffers from several flaws that discredit his final diagnosis that Claimant's condition "would be the same as it is now, had he never stepped foot in the mines." *Id*. at 32. First, his interpretation of the data includes a presumption that the x-ray evidence was negative. Second, his assessment was based on an incorrect smoking history of one-half pack to one pack a day for "most of his adult life." *Id*. at 31. Third, Drs. Crisalli, Boggs and Craft all determined that Claimant had bronchitis and Drs. Bellotte, Rasmussen, Craft and Stewart all determined that Claimant suffers from asthma. Both of these illnesses restrict the airways in the lungs, symptoms that are relieved by bronchodilator drugs, which would account for the fluxuating values of PO_2 in the arterial blood gas study. Dr. Fino admitted that it was possible to have both asthma and bronchitis at the same time as having pneumoconiosis, *Id*. at 38, but, did not adequately explain why Claimant, who continually suffered from

decreasing pulmonary capacity and low PO_2 ratings, could not have pneumoconiosis as well as emphysema or other pulmonary disease.

To make a diagnosis of pneumoconiosis, Dr. Fino stated that he would require the following things:

Q Well, what in your opinion is definitive of coal mine worker's pneumoconiosis? . . .

A Whatever the objective tests are that are positive for that condition. If it fits, that will make the diagnosis, whether it is a positive x-ray, a positive biopsy, a fixed type of abnormality in the lung functions which don't change, a fixed impairment in oxygen transfer. Any one of those may be just - - or may be definitive for pneumoconiosis, given the proper exposure and latency period.

Id. at 35.

Accordingly, here claimant has positive x-rays, his pulmonary functions are continually decreasing, and his oxygen transfer readings have been consistently low even though they show some variation. Additionally, Claimant's many years in the coal mines gives him the proper exposure and latency period. Therefore, Dr. Fino's conclusion that Claimant does not have pneumoconiosis, in light of his own assessment of how to diagnose pneumoconiosis, is not sound medical judgment.

Dr. Bellotte, a pulmonary disease specialist, reviewed Claimant's medical records and concluded that Claimant does not have pneumoconiosis, but does have chronic bronchitis, emphysema and asthma. Dr. Bellotte based his diagnosis on: the fact that Claimant's carbon monoxide level was high in his blood gas study; "a long smoking history;" small airway dysfunction; negative x-ray interpretations; and indicated that Claimant's asthma would not show any improvement with the use of bronchodilators if Claimant had pneumoconiosis. Dr. Bellotte's report is not a well reasoned medical opinion because it is based, in part, on negative x-ray readings and a smoking history that may be incorrect. Also, Dr. Bellotte did not explain why Claimant could not have both asthma or bronchitis, which would improve with the use of bronchodilators, and pneumoconiosis, in light of the fact that Claimant's arterial blood gas study showed consistently that Claimant suffered from low levels, despite some variations which could be due to the bronchodilator medicine.

Dr. Hippensteel, a pulmonary specialist, authored a consultative report on March 9, 1998, opining that Claimant did not have pneumoconiosis, after reviewing Claimant's extensive medical records. His decision was based, in part, upon negative x-ray readings, and a few positive readings, which he did not think showed results consistent with pneumoconiosis. Dr. Hippensteel recognized Claimant's history of pneumonia, bronchitis, and asthmatic bronchitis, and recognized periodic exacerbations of these conditions secondary to cigarette smoking. Dr. Hippensteel did not consider, however, the possibility that pneumoconiosis could be a substantial cause of Claimant's current condition. Therefore Dr. Hippensteel's medical opinion is not well reasoned because, as a matter of law, his interpretation of the x-ray evidence

was erroneous, and he did not explain why Claimant could have a non-coal mining respiratory impairment simultaneously with pneumoconiosis.

Dr. Loudon, a pulmonary specialist trained in England, concluded that there was insufficient evidence to diagnosis pneumoconiosis. Calling the diagnosis of pneumoconiosis an "inexact and contentious subject," Dr. Loudon based his opinion on the "radiologists' consensus"of negative x-ray films and the physiological data. Because I find the x-ray evidence shows pneumoconiosis, I give less weight to the opinion of Dr. Loudon.

Dr. Kress, a B reader, authored consultative reports in 1989 and 1990, reaching the conclusion that Claimant did not have pneumoconiosis. His opinion was based on radiographic evidence, three of which he personally interpreted, and the lack of objective findings consistent with pneumoconiosis. He determined that Claimant's air passages were obstructed, consistent with cigarette smoking, and not restricted, consistent with pneumoconiosis. As such, his report is not well reasoned because the radiographic evidence does show evidence of pneumoconiosis and Dr. Kress did not state that he considered the possibility that Claimant had multiple pulmonary impairments which would account for some fluxuation in the physiological data, and account for the evidence of some obstruction in the air flow passages.

1(c)(iii)(B) Physicians Finding Pneumoconiosis

Dr. Craft, one of Claimant's treating physicians from 1982-1983, concluded that occupational pneumoconiosis was the etiology of Claimant's pulmonary dysfunction. Although Dr. Craft does not set forth all the reasons for his opinion, he does state that he relied on chest x-rays that revealed linear fibrate changes in the bases, remarked that Claimant had a long history of coal mine employment, and stated that Claimant was a heave cigarette smoker. Dr. Craft also stated that Claimant had a history of chronic bronchitis, and emphysema with coal workers' pneumoconiosis. Accordingly, although Dr. Craft does not succinctly set forth all the factors and reasons upon which he based his conclusion, he did set forth three valid factors, and indicated that he considered the possibility that Claimant could have more than one pulmonary impairment, thus, his report is entitled to some probative value.

Dr. Boggs, Claimant's treating physician from 1977 to 1992, treated Claimant for arthritis, bursitis and pneumoconiosis. He based his diagnosis of pneumoconiosis on the fact that Claimant had a chronic cough, shortness of breath, weakness, decreased breath sounds and wheezes. There is no indication that Dr. Boggs considered x-ray evidence, pulmonary function tests, arterial or blood gas studies. Dr. Boggs was aware of Claimant's smoking and work history. Therefore, Dr. Boggs report is not well reasoned because he failed to consider all the factors available to diagnosis pneumoconiosis, but his report is entitled to some probative value because he had familiarity with Claimant's smoking and work history, and treated Claimant over the years under the belief that Claimant had pneumoconiosis.

Dr. Stewart treated Claimant since 1992 for COPD, equivocally diagnosing the etiology as pneumoconiosis. Dr. Stewart correctly documented a smoking history of one-half pack of cigarettes per day, and also noted that Claimant had acute asthma and bronchitis, with a chronic obstructive pulmonary disease. In 1996, Dr. Stewart opined that, clinically, Claimant demonstrates evidence of severe pulmonary interstitial fibrosis that is consistent with a diagnosis of pneumoconiosis, but when he made this diagnosis, he remarked that he only had the arterial blood gas studies done in the emergency room and did not have records of Claimants pulmonary function studies. Accordingly, Dr. Stewart's medical report is not well reasoned because he did not consider all the available data, but, the missing data - pulmonary function exam, radiographic evidence, length of exposure - all support a finding of pneumoconiosis, thus, if Dr. Stewart had these additional facts, it is highly likely that he would have concretely diagnosed pneumoconiosis.

Dr. Gaziano examined Claimant for the Department of Labor on February 16, 1996, concluding that Claimant suffers from both chronic obstructive pulmonary disease due to smoking, and coal workers' pneumoconiosis in equal measure. This conclusion was based on positive x-ray evidence, an incorrect smoking history of one pack per day since the age of twenty-two, the length of coal mine employment, and a history of pneumonia, wheezing, chronic bronchitis and bronchial asthma. I also note that Dr. Gaziano personally interpreted three of Claimant's x-rays over nine years, and participated in Claimant's pulmonary function studies and arterial blood gas studies. Furthermore, in Dr. Crisalli's deposition, Dr. Crisalli admitted that Dr. Gaziano had "good and hard scientific data to support his conclusion." (Crisalli Dep. 40). Accordingly, I find that Gaziano issued a well reasoned medical report diagnosing the existence of pneumoconiosis because his diagnosis was made based on an elevated smoking history, positive radiographic evidence, medical history, length of exposure, and because he had participated in both the pulmonary function and arterial blood gas studies.

Dr. Rasmussen examined Claimant in 1989 and issued supplemental reports in 1989 and 1990, concluding that Claimant has pneumoconiosis. Dr. Rasmussen correctly stated that Claimant smoked one-half pack of cigarettes a day, but incorrectly stated that Claimant quit in 1980. Dr. Rasmussen further noted a long period of exposure to coal dust, medical history, x-ray changes consistent with pneumoconiosis, physiological data - nearly all of which points to a severe pulmonary insufficiency - and noted that Claimant suffers from more than one pulmonary impairment. Accordingly, I find that Dr. Rasmussen issued a well reasoned medical opinion concluding that Claimant has pneumoconiosis.[3]

1(c)(iii)(C) Weighing the Medical Reports

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[3] Although Judge Burke declined to follow Dr. Rasmussen's opinion because of an incorrect assessment of the amount of Claimant's smoking, I find, that subsequent evidence by treating physicians, as well as Dr. Gaziano, who credited Claimant with a greater smoking history, supports Dr. Rasmussen's ultimate conclusion that both smoking and pneumoconiosis contributed to Claimant's lung impairment.

Therefore, I find that the medical reports of Drs. Crisalli, Fino, Bellotte, Hippensteel, Loudon and Kress are not well reasoned medical opinions because their reports do not consider, in differing degrees, a correct smoking history, positive X-ray evidence, and the possibility that Claimant is suffering from more than one pulmonary impairment. Furthermore, I note that the underlying premise of Drs. Crisalli, Fino, Bellotte, Hippensteel, Loudon and Kress, that Claimant does not suffer from pneumoconiosis, is inaccurate. Drs. Craft, Boggs and Stewart's opinion are not well reasoned because they fail, in differing degrees, to consider all the physiological data of the pulmonary function and arterial blood gas studies. On the other hand, Dr. Gaziano and Rasmussen, issued well reasoned opinions because they relied on positive x-ray evidence, physiological data, medical and work histories, and fully considered the pulmonary impairments based on both smoking and coal mining histories, not trying to discount the existence of one to favor the other.

1(d) Weighing the Whole Record to Determine the Existence of Pneumoconiosis

Weighing the record as a whole, I find that Claimant has established the existence of pneumoconiosis because: 1) a preponderance of the x-ray evidence is positive for pneumoconiosis; 2) Claimant is entitled to a presumption of pneumoconiosis under Section 718.305(a) because he worked over fifteen years in the coal mines and suffers from a respiratory impairment; and 3) Drs. Gaziano and Rasmussen issued well reasoned medical reports establishing that Claimant suffers from both smoking and coal mining related impairments.

2. Pneumoconiosis Arising from Coal Mine Employment

Before a Claimant can obtain black lung benefits, he must establish, by a preponderance of the evidence that his pneumoconiosis arose out of his coal mining employment. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 207 (4th Cir. 2000). A disease "'arising out of coal mine employment' includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. 20 C.F.R. § 718.201 (2000). Thus, to be eligible for benefits, "it must be determined that the miner's pneumoconiosis arose at least in part from coal mine employment." 20 C.F.R. § 718.203(a) (2000). Whenever a miner has worked in a coal mine for over ten years, and suffers from pneumoconiosis, there is a rebuttable presumption that the pneumoconiosis arose out of the coal mine employment. 20 C.F.R. § 718.203(b) (2000).

Here, I find that Claimant suffers from two pulmonary impairments, one relating to smoking, and the second related to Claimant's coal mine employment. As discussed *supra*, part 1(c)(iii)(A), Operator amply provided evidence of pulmonary impairments related to smoking, but, based the conclusion on an incorrect interpretation of the x-ray evidence, incorrect smoking histories, a refusal to discuss a dual etiology of Claimant's pulmonary impairments, and base their medical reports on an incorrect presumption

that Claimant did not suffer from pneumoconiosis. Operator has failed to rebut the presumption. Furthermore, even if operator had presented sufficient evidence to rebut the presumption of etiology, then I find, as discussed *supra*, part 1(c)(iii)(B), that the opinions of Drs. Gaziano and Rasmussen establish by a preponderance of the evidence that Claimant suffers from pneumoconiosis arising from coal mine employment.

3. A Totally Disabling Respiratory or Pulmonary Condition

Benefits are only awarded to miners who are totally disabled due to pneumoconiosis. 20 C.F.R. § 718.204 (2000). A miner is considered totally disabled if pneumoconiosis prevents the miner from performing his usual coal mine work and from engaging in gainful employment in the immediate area. *Id*. Here, there is no medical dispute that Claimant is totally disabled due to pulmonary impairments.

4. Pneumoconiosis as a Contributing Cause of Total Respiratory Disability

Before a coal miner may obtain black lung benefits, he must have pneumoconiosis that is a contributing cause to his pulmonary condition. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 207 (4th Cir. 2000). The Code of Federal Regulations assist the miner in establishing total disability due to pneumoconiosis:

> There is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis . . . if such miner is suffering . . . from a chronic dust disease of the lung which:
>
> (a) When diagnosed by chest X-ray . . . yields one or more large opacities (greater than 1 centimeter in diameter) . . . .

20 C.F.R. § 718.304 (2000).

Here, x-ray films showed by a preponderance of the evidence the Claimant had pneumoconiosis entitling Claimant to the irrebuttable presumption that his pneumoconiosis is a contributing cause to his respiratory disability. In addition to the x-ray evidence and the irrebuttable presumption, Claimant had a long history of exposure to coal dust in the mines. Drs. Gaziano and Rasmussen, whose reports are discussed *supra*, part 1(c)(iii)(B), both opined that pneumoconiosis and smoking contributed to Claimant's pulmonary impairment. Therefore, I find that pneumoconiosis is a contributing cause of Claimant's total respiratory disability.

5. Onset of Disability

When a miner is totally disabled due to pneumoconiosis, "benefits are payable to such miner beginning with the month of onset of total disability." 20 C.F.R. § 725.503(b) (2000). When the evidence does not clearly establish the date of onset, the "benefits shall be payable to such miner beginning with the month during which the claim was filed, . . ." *Id*. A miner who files a duplicate claim cannot receive benefits for any time preceding the final adjudication of the prior claim. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1364 (4th Cir. 1996).

Claimant argues that the date of onset of total disability should be July 1, 1992, the date Dr. Boggs started treating Claimant for the existence of pneumoconiosis. The denial of Claimant's second claim for benefits became final on August 10, 1993, and Claimant filed his third claim for benefits on December 14, 1995. Accordingly, when Dr. Boggs began treating Claimant for pneumoconiosis in 1992, his second claim was not yet final. In February 1996, Dr. Gaziano detected the presence of pneumoconiosis on an x-ray, and further, on the same date, after an examination of Claimant, found qualifying blood gas levels and properly attributed Claimant's respiratory insufficiency in equal measure to pneumoconiosis and COPD. Similarly, this represents a material change in condition from earlier duplicate claims, entitling Claimant to benefits. Accordingly, I find that Claimant is entitled to benefits as of February 16, 1996.

III. ORDER

IT IS ORDERED that the claim for benefits, filed by Varis Canfield, is granted and benefits are payable commencing February 16, 1996.

IT IS FURTHER ORDERED that, Claimant's counsel is allowed thirty (30) days from the date of service of this decision to submit an application for attorney's fees. A service sheet showing that service has been made on all parties, including the Claimant, must accompany the petition. Parties have twenty (20) days following the receipt of such application within which to file any objections thereto.

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CLEMENT J. KENNINGTON
Administrative Law Judge

NOTICE OF APPEAL RIGHTS Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this order, by filing a notice of appeal with the Benefits Review Board at P. O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq.,

Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N. W., Washington, DC 20210.